

PA-G

**STATE OF ALABAMA**  
**DEPARTMENT OF INSURANCE**  
QUARTERLY PREMIUM TAX STATEMENT – HEALTH MAINTENANCE ORGANIZATION  
**Quarterly Period Ending September 30, \_\_\_\_\_**  
(Due no later than November 15, \_\_\_\_\_)

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**INSTRUCTIONS**

**PENALTIES** – Any Company failing to file its Premium Tax Return (even if no tax is due) or failing to pay such estimated taxes on a timely basis shall be subject to a penalty of \$1,000 to \$10,000, to be assessed by the Commissioner.

**RETURNS POST MARKED ON THE DUE DATE WILL BE ACCEPTED.**

**Please use the following checklist to assure that all the necessary items are included with your Premium Tax Filing.**

( ) Each quarter's payment may be paid on Estimated or Actual premiums.

( ) Make checks payable to the: Alabama Department of Insurance.

( ) **WE DO NOT HAVE AN EFT ACCOUNT AT THIS TIME.** Premium Tax Return and Check must be mailed to the address below:

**POSTAL SERVICE**

Alabama Department of Insurance  
c/o Compass Bank  
P.O. Box 830691  
Birmingham, AL 35283-0691

**COURIER OR EXPRESS SERVICE**

Alabama Department of Insurance  
c/o Compass Bank  
701 South 32<sup>nd</sup> Street  
Birmingham, AL 35233

NAIC#:

\_\_\_\_\_  
(Name of Company)

\_\_\_\_\_  
Preparer's Signature

\_\_\_\_\_  
Name and Title (Print)

\_\_\_\_\_  
Telephone No.

**PLEASE COMPLETE**

**1. PREMIUM TAX PAID:** (reverse side, line 9)

**PA:**

\$

**2. Check No.:** -----

\_\_\_\_\_

**STATE OF** \_\_\_\_\_ **COUNTY OF** \_\_\_\_\_

**Personally appeared before the undersigned attesting officer(Name)**

\_\_\_\_\_

**Who says he/she is (Title)** \_\_\_\_\_ **of the above company and the above statement is true and correct to the best of his/her knowledge.**

**SWORN TO AND SUBSCRIBED** before me this \_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

--OVER--

**HEALTH MAINTENANCE ORGANIZATION**  
**Quarterly Period Ending September 30, \_\_\_\_\_**  
(Due no later than November 15, \_\_\_\_\_)

**PA-G**

**NAIC NO: \_\_\_\_\_**

**TAXABLE PREMIUMS**

**ACTUAL:**

**THIS QUARTER    TAX RATE    TAX**

**3. Health:**

- a) Groups less than 50 participants  
b) Other Health, excluding insurance  
supplementary to Medicaid or Medicare &  
employer sponsored, governmental sponsored  
group insurance

\$ \_\_\_\_\_ X .5% = \$ \_\_\_\_\_

\$ \_\_\_\_\_ X 1.6% = \$ \_\_\_\_\_

**4. GROSS TAX DUE – ACTUAL BASIS**

\$ \_\_\_\_\_

**ESTIMATED:**

**PREVIOUS YEAR    TAX RATE    TAX**

**5. Health:**

- a) Groups less than 50 participants  
b) Other Health, excluding insurance  
supplementary to Medicaid or Medicare &  
employer sponsored, governmental sponsored  
group insurance

\$ \_\_\_\_\_ X 25% X .5% = \$ \_\_\_\_\_

\$ \_\_\_\_\_ X 25% X 1.6% = \$ \_\_\_\_\_

**6. GROSS TAX DUE - ESTIMATED BASIS**

\$ \_\_\_\_\_

**7. 25% of deductible expenses paid or estimated to be paid**

\$ \_\_\_\_\_

**8. LESS: Prior Year Overpayment**

\$ \_\_\_\_\_

**9. NET PREMIUM TAX DUE**

(line 4 or line 6 minus lines 7 and 8)

\$ \_\_\_\_\_

**Report the Amount Paid, Check Number, and Date of Check in the following schedule.**

<b>TAXES PAID:</b>	1 <sup>st</sup> Quarter \$ _____	Check No. _____	Date paid _____
	2 <sup>nd</sup> Quarter \$ _____	Check No. _____	Date paid _____
	3 <sup>rd</sup> Quarter \$ _____	Check No. _____	Date paid _____